MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5702

Reg. Dist. No. 05691

1. PLACE OF DEATH
a. COUNTY: Kent
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Millington
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FANNIE Middle B. Last BAILEY

4. DATE OF DEATH: Month May Day 13, Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February 11, 1873

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel K. Fretz

14. MOTHER'S MAIDEN NAME: Mary E. Bayer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Mary Bramble, Address: Millington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 yrs
334 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): General Arterio-sclerosis — 10 years
DUE TO
(c): Senility — year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.: None 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 1957 19__ to May 13 19 59, that I last saw the deceased alive on May 13, 19 59, and that death occurred at 1130 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. H. Hamilton M.D.
ADDRESS (Street, city or town, state): Millington Md
DATE SIGNED: 5/12/59

PHYSICIAN'S NAME (Type): H. H. HAMILTON
MILLINGTON MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May, 16, 1959
22c. NAME OF CEMETERY OR CREMATORY: Millington Cemetery
22d. LOCATION (City, town, or county) (State): Millington, Kent Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward L. Fellows
ADDRESS: Millington Md
24a. REC'D BY REGISTRAR DATE MAY 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5692 CERTIFICATE OF DEATH

05692
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: adult life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Chestertown
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah Middle: E. Last: Cann

4. DATE OF DEATH: Month: May Day: 12 Year: 1959

5. SEX: female

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 21, 1914

9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Cann

14. MOTHER'S MAIDEN NAME: Katie Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-20-7679

17. INFORMANT: Levenia Maynor
Address: Chestertown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH:
460 X
DUE TO (b): Thrombophlebitis Lt leg — 1-2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Varicosities

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Marked Obesity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 12, 1959, to May 12, 1959, that I last saw the deceased alive on May 12, 1959, and that death occurred at 11:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry Paul Ross M.D.
ADDRESS (Street, city or town, state): 203 N. Queen St
DATE SIGNED:
PHYSICIAN'S NAME (Type): Harry Paul Ross M.D. Chestertown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 16, 1959
22c. NAME OF CEMETERY OR CREMATORY: Janes Cem.
22d. LOCATION (City, town, or county) (State): near Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walker
ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: MAY 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5693 — Reg. Dist. No. 05693

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent and Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sudlersville 17x-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LeRoy — Middle: Hodge — Last: Coleman

4. DATE OF DEATH: Month: May — Day: 16 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 4, 1895

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: W. Rudolphus Coleman

14. MOTHER'S MAIDEN NAME: Anna Nicholson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hosp. Records, Chestertown Md. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days
420.1
DUE TO (b): Coronary artery disease — 7 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-13, 1959, to 5-16, 1959, that I last saw the deceased alive on 5-16-59, 1959, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick M.D. — ADDRESS (Street, city or town, state): Chestertown, Md. — DATE SIGNED: 5-16-59

PHYSICIAN'S NAME (Type): A. C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: MAY 20 — 22c. NAME OF CEMETERY OR CREMATORY: CRUMPTON — 22d. LOCATION (City, town, or county): CRUMPTON (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lord — ADDRESS: Church Hill

24a. REC'D BY REGISTRAR — DATE: MAY 21 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item7 FilmG243 5/28/59 cap

CERTIFICATE OF DEATH

05694

Reg. Dist. No. 5703

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): near Still Pond
c. LENGTH OF STAY IN 1b: adult life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Still Pond
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph; Middle:; Lost: Davis

4. DATE OF DEATH: Month: May; Day: 20; Year: 1959

5. SEX: male

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Apr. 12, 1865

9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Don't Know

14. MOTHER'S MAIDEN NAME: Don't Know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Don't Know

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Kent Co. Welfare Board — Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterial Thrombosis
DUE TO (b): old age.
DUE TO (c):

454X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m.; Month:; Day:; Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 15 1959, to May 20, 1959, that I last saw the deceased alive on May 20th 1959, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. P. Atwell M.D.
ADDRESS (Street, city or town, state): Still Pond, Md.
DATE SIGNED: 5/21/59

PHYSICIAN'S NAME (Type): L. P. Atwell

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/23/59
22c. NAME OF CEMETERY OR CREMATORY: Still Pond Cem.
22d. LOCATION (City, town, or county) (State): Still Pond, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Waller
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: MAY 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Knowles

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05695

CERTIFICATE OF DEATH

5704

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Kent MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First FANNIE Middle A. Last DIXON

4. DATE OF DEATH Month May Day 23, Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH April, 24, 1867
9. AGE (In years last birthday) 92 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Emory Camp
14. MOTHER'S MAIDEN NAME Susan A. Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mrs. Pearle Fogwell, Galena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 332X Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Arteriosclerosis — years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1, 1959, to May 23, 1959, that I last saw the deceased alive on May 23, 1959, and that death occurred at 9:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wallace Obenshain M.D. ADDRESS (Street, city or town, state) Ceculton, Md DATE SIGNED 25 May 59

PHYSICIAN'S NAME (Type) WALLACE OBENSHAIN

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF May, 27, 1959
22c. NAME OF CEMETERY OR CREMATORY Galena Cemetery
22d. LOCATION (City, town, or county) (State) Galena, Kent Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows. ADDRESS Millington Md
24a. REC'D BY REGISTRAR DATE MAY 28 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5705 - **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Item9 FilmG243 5/27/59 cap

05696

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Piney Neck

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rock Hall
d. STREET ADDRESS: Piney Neck
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: Gaines

4. DATE OF DEATH: Month: May — Day: 16 — Year: 1959

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 10, 1911

9. AGE (In years last birthday): 47 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: cannery

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Hynson

14. MOTHER'S MAIDEN NAME: Mattie Black

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 212-30-8156

17. INFORMANT: William Hynson — Address: Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: Anasarea — 2 months

(c) DUE TO: Probable Hepatitis and Cirrhosis of Liver — 1 or 2 years

581.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert W. Farr M.D.

EXAMINER'S NAME (Type): Robert W. Farr, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 5/18/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/18/59

22c. NAME OF CEMETERY OR CREMATORY: Sharptown Cemetery

22d. LOCATION (City, town, or county) (State): Rock Hall, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: MAY 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05697

5706 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Kent — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall — c. LENGTH OF STAY IN 1b: 42 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Rock Hall
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Main St. + Haven Rd	d. STREET ADDRESS: Main St. + Haven Rd. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Emma	Middle: I	Last: Hanna	4. DATE OF DEATH	Month: May	Day: 13	Year: 1959	
5. SEX: F.	6. COLOR OR RACE: W.	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: April 19, 1876	9. AGE (In years last birthday): 83 yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeping	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Baltimore Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles W. Hanna	14. MOTHER'S MAIDEN NAME: Catherine Crawford		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Mrs. Mattie J. Davis	Address: Rock Hall Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Senility
794X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that I attended the deceased from March, 1959, to May 13, 1959, that I last saw the deceased alive on May 13, 1959, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Leslie M.D. — ADDRESS (Street, city or town, state): Rock Hall — DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 5/16/59	22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem.	22d. LOCATION (City, town, or county) (State): Rock Hall Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams	ADDRESS: Chestertown Md	24a. REC'D BY REGISTRAR DATE: MAY 19 '59	24b. REGISTRAR'S SIGNATURE: Arthur S Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05698

Reg. Dist. No. 5699

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown
c. LENGTH OF STAY IN 1b les than 1 day
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Pennsylvania
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia
75 X-3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Kent & Queen Anne Hosp.
d. STREET ADDRESS 6911 Linmore Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Russell Middle G Last Smith
4. DATE OF DEATH Month May Day 30 Year 19 59

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 13, 1917
9. AGE (In years last birthday) 41 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction
10b. KIND OF BUSINESS OR INDUSTRY Building
11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert Smith
14. MOTHER'S MAIDEN NAME Mary Lawrence

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 2
16. SOCIAL SECURITY NO.
17. INFORMANT Address Personal papers found in carx of deceased

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 353.1
DUE TO (b)
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Unknown, but possibly due to a combination of natural and accidental causes. Frequently a patient in VA hospital. Carried drug resembling Dilantin. Had had an old operation on left side, upper frontal area of head. Was drinking, dove into water, was pulled out, vomited at 5 P.M. Seen by MD who said he had rales & wheezing in chest & advised hospital. Died en route at about 9:30PM. Had been talking

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a)

WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II above) dove in water at Kennedyville Park Md, May have had a seizure after entering water.

20c. TIME OF INJURY Hour 5 a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Waterfront near Kennedyville, Kent, Md.
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, ? Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE Robert W. Farr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED May 31, 1959

EXAMINER'S NAME (Type) Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 6/3/59
22c. NAME OF CEMETERY OR CREMATORY Beverly Nat. Cem.
22d. LOCATION (City, town, or county) (State) Beverly New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells
ADDRESS Chestertown, Md.
24a. REC'D BY REGISTRAR DATE JUN 2 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kunkel

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5707 CERTIFICATE OF DEATH

Reg. Dist. No. 05699

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RFD Edesville

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rock Hall
d. STREET ADDRESS: RFD Edesville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Natasha — Middle Lynette — Last Stewart

4. DATE OF DEATH: Month May — Day 29, — Year 1959

5. SEX: female

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 26, 1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months 2 — Days 3
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Cleveland Stewart

14. MOTHER'S MAIDEN NAME: Mary Ann Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Mary Ann Thomas Stewart — Address: Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Premature Transition, — INTERVAL BETWEEN ONSET AND DEATH
773.5
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) /

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/29, 1959, to 5/29, 1959, that I last saw the deceased alive on Dead 5/29, 1959, and that death occurred at 2:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E Kester, M.D. — ADDRESS (Street, city or town, state): Rock Hall, Md. — DATE SIGNED: 5/30/59

PHYSICIAN'S NAME (Type): Eugene Kester — MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: May 30, 1959 — 22c. NAME OF CEMETERY OR CREMATORY: Sharptown Cem. — 22d. LOCATION (City, town, or county) (State): Rock Hall, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Weller — ADDRESS: Chestertown, Md.
207220 XV 2

24a. REC'D BY REGISTRAR DATE: JUN 1 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05700

5708 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LILLIE Middle Last THOMAS

4. DATE OF DEATH Month May Day 15, Year 1959

5. SEX Female

6. COLOR OR RACE Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH July 12, 1888

9. AGE (In years last birthday) 70 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Elliot Brown

14. MOTHER'S MAIDEN NAME Lillie Ford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Waman Thomas, Address Millington, Md. R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident (Coma). — INTERVAL BETWEEN ONSET AND DEATH: 3 days

331X

DUE TO (b) Atherosclerosis — 15-20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Cerebral hemorrhage hemiplegia — 14 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 22, 1959, to May 15, 1959, that I last saw the deceased alive on May 12, 1959, and that death occurred at 12:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Alex Koralewski M.D. ADDRESS (Street, city or town, state) MILLINGTON MD DATE SIGNED 5-16-59

PHYSICIAN'S NAME (Type) ALEX KORALEWSKI

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF May 18, 1959

22c. NAME OF CEMETERY OR CREMATORY Chesterville Cemetery

22d. LOCATION (City, town, or county) (State) Rural Millington, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows ADDRESS Millington, Md.

24a. REC'D BY REGISTRAR DATE MAY 19 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be [illegible] for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05701

5700 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Worton

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Elva — Middle: Elizabeth — Last: Wessell

4. DATE OF DEATH: Month: May — Day: 18 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-17-12

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Jackson

14. MOTHER'S MAIDEN NAME: Alice Cranor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Hosp. Kent Co.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): post operative

465X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-12, 19 59, to 5-18, 19 59, that I last saw the deceased alive on 5-18, 19 59, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A C Tick M.D.

ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type): A. C. Tick — Chestertown, Md — 5-19-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 21, 1959

22c. NAME OF CEMETERY OR CREMATORY: Chester Cem.

22d. LOCATION (City, town, or county) (State): Chestertown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows — ADDRESS:

24a. REC'D BY REGISTRAR DATE: MAY 25 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5701

05702 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: less than 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Annes

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Worton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Raymond — Middle Alfred — Last Wilson

4. DATE OF DEATH: Month May — Day 30 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aptil 3 1931

9. AGE (In years last birthday): 28 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James E. Wilson

14. MOTHER'S MAIDEN NAME: Hynson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1951-1953

16. SOCIAL SECURITY NO.: 215-26-5795

17. INFORMANT — Address: Magnolia Wilson Worton, Md. (Wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Natural (Probably coronary thrombosis) — INTERVAL BETWEEN ONSET AND DEATH: ½ hour

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Deceased, previously perfectly well awakeened

DUE TO (c): from his sleep and complained of severe pain in his c

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): chest and back, which radiated to his arm. He took bicarbonate — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. (DESCRIBE HOW INJURY OCCURRED (Homicide, suicide, injury in field or home) for presumed indigestion, and fell over unconscious after about ½ hour. Was dead on arrival at the hospital.

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert W Farr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: May 30, 1959

EXAMINER'S NAME (Type): ROBERT W. FARR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/3/59
22c. NAME OF CEMETERY OR CREMATORY: Butlertown Cem.
22d. LOCATION (City, town, or county) (State): Worton, Md. Kent Co.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walker
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: JUN 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 8M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5709

Reg. Dist. No. 05703

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Galena

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Galena

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

d. STREET ADDRESS /

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: F.; Last: Wise

4. DATE OF DEATH: Month: May; Day: 21; Year: 19 59

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 26, 1891

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Arthur Caulk

14. MOTHER'S MAIDEN NAME: Hester Vilo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: James Wise, Address: Golts, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute heart failure — INTERVAL BETWEEN ONSET AND DEATH: 6 days

416X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Degeneration of the Myocardium. — 2 years

DUE TO (c): Rheumatic heart disease — 2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 24, 19 58 to May 21, 19 59, that I last saw the deceased alive on May 18, 19 59, and that death occurred at 7:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Geza Koralewski M.D. ADDRESS (Street, city or town, state): Millington, Md DATE SIGNED: 5.22.59

PHYSICIAN'S NAME (Type): GEZA KORALEWSKI

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/25/59

22c. NAME OF CEMETERY OR CREMATORY: Olivet Hill Cem.

22d. LOCATION (City, town, or county): Rural Galena (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Pellow ADDRESS: Millington Md.

24a. REC'D BY REGISTRAR DATE: MAY 27 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55